series was “strongest for younger females.” Pelvic operations in females rank high among unnecessary procedures and thus a frequent cause of lost time from work.

The crucial clinical investigation has yet to be performed: A comparison of results and costs under high quality prepaid health plans and care rendered by like quality fee-for-service group or solo practitioners. My impression is that such a study would reveal no medical cost savings of a prepaid plan that are not offset by the well-known inconveniences and other disadvantages of this type of health care delivery system.

I congratulate Robertson for his further confirming that the quality of medical care is of an unacceptably uneven texture in this country.

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TO THE EDITOR:

A Reply to Dr. Gerber

I am pleased that Dr. Alex Gerber has found my paper of sufficient interest to warrant a response. It is highly desirable that specialists of many disciplines, such as medicine and economics, engage in dialogues concerning health and medical care. It is gratifying that he refers to me as “a careful writer.” However, it is not clear why he thinks that many other readers will be less careful than he in analyzing my conclusion. I assumed when writing—and still assume—that the American Journal of Public Health has a literate and knowledgeable readership.

Gerber and I agree that it is difficult—often impossible—to conduct rigidly controlled experiments in order to assess the effects of personal health services. While searching for the setting for his "crucial clinical investigation" (if it exists), we appear to disagree on the desirability of studying and reporting comparative experiences of samples examined under less than ideal research conditions.

Gerber is troubled particularly by possible differences among medical providers in a project like mine. His concern is that some of the physicians and hospitals extending services to the “blue” plan subscribers are likely to perform so poorly, relative to the prepaid group practice program components, that a clear comparison of work loss cannot be made. Readers of the article and these comments will draw their own conclusions. There are several considerations to be borne in mind when reflecting upon the issues.

As a physician, Gerber doubtless has knowledge of “untrained and unqualified surgeons at third-rate hospitals.” Nevertheless, his generalities with sweeping references to “California (and other western states)” do not demonstrate the degree to which his fears apply to my research population. In extensive discussions with many persons in the city under study—including representatives of the blue plan offering free choice of practitioners and institutions—I have not received any comments to support Gerber’s contentions. Ironically, there are writers who believe that a prepaid group practice plan might be the one whose staff is at a disadvantage through such problems as limited access of its patients to hospital beds.* That difficulty, also, does not seem to apply to the specific research setting here.

Even if, for purposes of argument, one were to concede that fee-for-service medical providers are of more question-able quality than those in prominent prepaid group practice plans, there is a further point to be made. The differ-

* See, for example, the writings of H. E. Klarman, e.g., Medical Care, (May-June), 1969, p. 184.
ences between prepaid group programs and fee-for-service practices in compensating physicians are likely to account for some of the differential work loss observed. It is unfortunate, as I note in my paper (p. 38), that available data have not allowed us to distinguish between the effects of the fee system and of other variables. All things considered, in the absence of grounds for serious concern over comparability and lacking feasible "quality" controls, I have considered it appropriate to proceed with my report.

There can be general agreement on the need for additional work in this field. Indeed, in the paper I note that comparisons of health service utilization patterns of the samples within the study population represent another phase of my project (to be reported subsequently), and that more extensive work is warranted in addition.

In that spirit, I urge Dr. Gerber and other readers to study the aspects of our subject which they consider most important and interesting. Few of these investigations are apt to be conducted under ideal conditions, including the existence of practitioners and facilities that are matched exactly as to quality. Still, at a time when the health services industry is under broad scrutiny and attack for its performance, and when expenditure priorities are troublesome, we must continue to provide economic and other information for private and public policy-makers. The research agenda is too compelling for us to eliminate natural experiments and partially controlled studies, honestly reported, while awaiting the perfect case.

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An Illusory Goal?

In Europe and North America, medicine has achieved a high level of both therapeutic and preventive control over the traditional killing and debilitating diseases and, in the "developing" nations, it is making inroads. But if the goal of medicine is not to just lower the death rate, but also to eliminate disease, then the goal is illusory, as Dubos and others have insisted. The elimination of one health hazard frequently creates a niche for another disease or malady, resulting in only a change of the nature of man's ailments, not in the fact, or even the degree, of his affliction. Thus, while modern technology and affluence have helped create a more comfortable micro-environment in many respects, they also have created the smog-bound, corpulent, anxious, self-disparaging, unexercised, alienated, and pesticide-threatened human organism.